Form 499- A (part II)
11/85

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CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first
(doctor or clinic)
asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to representatives of the Department of Health, Education, and Welfare or employees of programs or projects funded by that Department, but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date:_____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check}

- ☐ American Indian or
- ☐ Black (not of Hispanic origin)
- ☐ Alaska Native
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White (not of Hispanic origin

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

_____
Interpreter *Date*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of Physician obtaining consent *Date*

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the nature of the
operation
sterilization operation _____, the fact that
specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. 1 explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2} This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery: (describe circumstances}:

_____

_____
Physician *Date*

INSTRUCTIONS FOR STERILIZATION CONSENT FORM (Form 499-A)

A. POLICY REFERENCES

(1) Utah Medicaid Provider Manual for Physician Services, SECTION 2, Chapter 3, Limitations, item S:

"Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441 Subpart F. Refer to the instructions for Criteria #10, Sterilization / Other Genito-urinary Procedures, in the attached Medical and Surgical Procedures List."

(2) Medical and Surgical Procedures List, Hospital Surgical Procedures Code List, Criteria #10 (Sterilization/Other Genito-urinary Procedures)

A. Client must be 21 years of age at time consent is signed
B. Client must be mentally competent to sign consent
C. For a client who is pregnant, the consent must be signed at least 30 days before the expected delivery date. This is true even in the case of the emergency exception explained in paragraph 2 of Form 499-A (Medicaid Sterilization Consent Form) under the heading PHYSICIAN'S STATEMENT.
D. Client must not be in an institution (for example, Utah State Hospital) or correctional facility (for example, Utah State Prison)
E. Procedure must be performed no sooner than 30 days after the client signs the consent and no longer than 180 days, unless it meets the requirements of the Medicaid Sterilization Consent Form (Form 499-A), in item (2) under the heading PHYSICIAN'S STATEMENT.
F. Signed sterilization consent must be witnessed and dated by a physician or nurse

Note: If the procedure is performed for medical reasons, other than voluntary sterilization, the usual 30 day waiting period for sterilization may be waived.

B. REQUIREMENT FOR ORIGINAL FORM IN TRIPLICATE

The form on the reverse side is a *copy* of the Medicaid Sterilization Consent Form. Medicaid requires an original form to be completed in triplicate. A supply of three-part forms may be ordered from the Medicaid agency. Contact Medicaid Information:

Salt Lake City area: **538-615**
Toll-free in Utah and the surrounding states of Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado: **1-800-662-9651**
From all other areas: **1-801-538-6155**

C. DISTRIBUTION OF COPIES

Return completed top copy of original to Medicaid, attention Prior Authorization:

MEDICAID PRIOR AUTHORIZATION UNIT
P.O. BOX 143103
SALT LAKE CITY UT 84114-3103

Second copy of original is for the physician.

Third copy of original is for the patient.